Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BURDIN CHIROPRACTIC NEURO & REHAB GROUP
9502 COMPUTER DR SUITE #200
SAN ANTONIO TX 78229

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-09-7791-01

MFDR Date Received
APRIL 23, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the Division of Workers Comp. Rules, the provider is not required to request pre-authorization within the first two weeks of the date of injury. This date of service falls thirteen days after the patient reported the injury. According to this rule, the carrier is obligated to pay for services rendered during the first two weeks without pre-authorization. We were denied payment on January 16, 2009 due to absence of pre-authorization or pre-certification and again on April 6, 2009 for the same reason. Our office is now seeking reimbursement through the assistance of the Division of Workers Compensation."

Amount in Dispute: $70.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office will maintain denial for CPT code 97035 and GO283 for 197-Payments adjusted for absence of preauth, as the treatment/services appear to be outside the ODG treatment guidelines (rule §137.100) for the indicated diagnosis(s) 847.1 Sprain/Strain Thoracic, 847.0 Sprain/Strain Cervical, 8472 [sic] Sprain/Strain Lumbar."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 31, 2008	Physical Therapy Services	$70.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §137.100 sets out the procedures for health care under the treatment guidelines.
5. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization of medical treatment.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - 197 – Payment adjusted for absence of precert/preauth.
    - W1 – Workers' Compensation State Fee Schedule adj
    - GP – Services

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.307?
2. Was preauthorization under 28 Texas Administrative Code §134.600 required?
3. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
4. Are the disputed services outside the ODG treatment guidelines?
5. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. In accordance with §133.307(c)(1)(A) requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the division. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. Subparagraph (B)(ii) states that a request may be filed later than one year after the date(s) of service if a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the carrier previously denied payment based on medical necessity.
2. The disputed CPT Codes G0283 and 97035 with initially denied using reason code 197 – "Payment adjusted for absence of precert/preauth." In accordance with 28 Texas Administrative Code §134.600(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (C)except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i) the date of injury... The injured workers date of injury is December 18, 2008; therefore for the dispute date of service of December 31, 2008 does not require preauthorization. However, because the disputed date of service does not require preauthorization it is subject to retrospective review. In accordance with 28 Texas Administrative Code §133.307(d)(2)(B) the response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MDR will be dismissed in accordance with subsection (e)(3)(G) or (H) of this section. In accordance with 28 Texas Administrative Code §133.307(e)(3)(G) the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General).
3. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--

General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution.

4. In accordance with 28 Texas Administrative Code §137.100(d) The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless: (1) the treatment(s) or service(s) were provided in a medical emergency; or (2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title. Review of the submitted documentation finds that the insurance carrier denied the services per the Official Disability Guidelines. According to subparagraph (e) an insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonable required. According to 28 Texas Administrative Code §137.100(f) states that a health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title. Review of the documentation submitted by the requestor does not support the services rendered complied with the Official Disability Guidelines and confirms that preauthorization was not requested for the services billed. Documentation was not submitted to support that the issues of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
5. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 3, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.